OFFICER/EMPLOYEE REQUEST FOR HIV, HEPATITIS B and/or HEPATITIS C TESTING OF ARRESTEE, CORRECTIONAL FACILITY INMATE, PAROLEE, OR PROBATIONER

In Accordance with Michigan Public Act 57 of 1997 (MCL 333.5204)

Michigan Department of Community Health

NOTICE TO EXPOSED INDIVIDUAL:

- Because of your exposure, it is recommended that you undergo an HIV antibody test, and tests for both Hepatitis B and Hepatitis C, and be evaluated for prophylaxis by your health care provider against these diseases.
- A request for testing must be made within 72 hours of exposure.
- After completing SECTION 1 of this form, please give this form to your employer.
- See pages 2, 3 and 4 for PA 431 and non-discrimination information.

SECTION 1 – To be completed by EXPOSED OFFICER / EMPLOYEE: *(See definition ❶ below)*

1. Name of Exposed Individual		Home Phone Number ( )		
Home Address (Number & Street, etc.)		City	State	ZIP Code
2. Name of Employer		Employer Phone Number ( )		
Employer Address (Number & Street, etc.)		City	State	City
3. Name of Source Individual ***(NOTE: The name should be provided ONLY when the source individual can be identified in NO OTHER WAY).***				
4. Source Individual ID Number	5. Date of Exposure	6. Approximate Time of Exposure : ☐ **AM** ☐ **PM**		

7 Route of Exposure:

☐ **Open Wound** ☐ **Mucous Membrane** ☐ **Percutaneous** (Needle stick Injury)

8. Provide a detailed description of the exposure while you were performing official duties: *(Attach additional sheet as needed)* ***(See ❷ Below)***

9. Based on my exposure described above, I am requesting that this source individual be tested for the following: *(Check all that apply)*

☐ **HIV** ☐ **Hepatitis B** ☐ **Hepatitis C**

10. Where do you want the Test Results Sent to: *(Check all that apply)*

☐ **Me at my Home** (Address Above) ☐ **My Physician** *(Complete item #**11** below)*

☐ **Me at Work** (Address Above) ☐ **Other Health Care Professional** *(Complete item #**12** below)*

11. Name of Your Physician		Physician Phone Number ( )		
Physician Address (Number & Street, etc.)		City	State	City
12. Name of Other Health Care Professional		Other Health Care Professional Phone Number ( )		
Other Health Care Professional Address (Number & Street, etc.)		City	State	City

- I understand that the NAME of the source individual to be tested, and that person's test results are confidential according to Sections 5111(2) and 5131 of Michigan Compiled Laws (MCL). I understand that a person who discloses information in violation of this Section is guilty of a misdemeanor.
- I also understand that I am ultimately responsible for the payment of the charges associated with the testing of this individual to whom I have been exposed, unless an agreement has been worked out between me and my employer, or is otherwise covered by my health care or benefits plan.

13. Signature of Exposed Individual	Date

❶ "Officer / Employee" means a police officer, fire fighter, local correctional officer, or other county employee, court employee, or an individual making a lawful arrest, who has received training in the transmission of blood-borne diseases, and who, while performing his or her official duties, or otherwise performing the duties of his/her employment, determines that he or she has sustained an exposure.

❷ "Exposure" means a percutaneous, mucous membrane, or open wound exposure to the blood or body fluids of an arrestee, correctional facility inmate, parolee, or probationer.

SECTION 2 – To be completed by EMPLOYER of Exposed Individual:

INSTRUCTIONS TO EMPLOYER:

Please forward a copy of this **entire** form (ALL PAGES) to the local health department, or other designated health care provider, who will be collecting the specimen and/or performing the test(s).

Please keep a copy of Sections 1 and 2 for your file. A copy of Section 4 will be returned to you after testing is completed. Please note that you are subject to the same confidentiality standards under the law (about the test subject's name, identity and test results) as the exposed individual/employee.

1. Name of Exposed Individual		
2. Has the exposed individual been previously trained in the transmission of bloodborne diseases as defined under the Occupational Safety and Health Administration's Bloodborne Pathogen Standard, issued December 6, 1991?	☐ **NO** ☐ **YES** ➔	If yes, Date of Training(s)
3. Has the Test Subject (Source Individual) agreed to be tested? ☐ **YES** ☐ **NO** ➔ 4. Has an HIV test consent form been signed? ☐ **YES** (Keep a copy on file) ☐ **NO**	If the source individual refuses to undergo one or more tests specified in the request, the requestor's employer may proceed with a petition to the family division of the circuit court, in the manner as specified under Section 5205 or 5207 of Michigan Compiled Law.	
5. Name of Agency doing Testing		
6. Complete Address of Testing Agency		
7. Name of Employer (Agency)		
8. Employer Authorized Signature Date	9. Employer Authorized Name (Printed or Typed) 10. Title of Authorized Signature	

NOTICE TO EMPLOYER:

Under the law, the employer is responsible for transporting the test subject to the local health department or designated health care provider for testing. Alternatively, arrangements can be made with the local health department or designated health care provider to go to where the test subject is held or housed.

When requesting testing, the appropriate test requisition form(s), as specified by the agency that is doing the testing, must be completed. It is best to have an agreement or understanding with a particular local health department, or other health care provider, regarding the performance of the test before using this form.

AUTHORITY: M.C.L. 333.5204 **COMPLETION:** Is voluntary, but is required if testing of the source individual is desired.	The Department of Community Health is an equal opportunity employer, services and programs provider.

SECTION 3 – To be completed by the Local Health Department or by Other Testing Agency:

Attention: Local Health Department / Testing Agency:
After completing Part III, this form should be transmitted ONLY to the **exposed individual, the designated physician, or other health care professional** as specified under Part I (page 1).

Notice to Physician or other Health Care Professional:
These test results are being forwarded to you as requested by the exposed individual listed below, as a result of his/her exposure to blood or other body fluids of an arrestee, correctional facility inmate, parolee, or probationer. This request for testing by the exposed individual is allowed under Michigan Public Act 57 of 1997. You may wish to consider HIV, Hepatitis B, and/or Hepatitis C testing of the exposed individual, and may want to consider prophylactic treatment based upon your evaluation.

1. Name of Exposed Individual	2. Source Individual **ID No**. (The ID Number is **preferred**, but if no number, enter name)

3. Source Individual was Tested for:

☐ **HIV** ☐ **Hepatitis B** ☐ **Hepatitis C** ☐ **All Three**

4. **TEST RESULTS on Source Individual:**

HIV:	**Rapid Test:**	☐ **Reactive***	☐ **Non-Reactive**	
	EIA:	☐ **Reactive**	☐ **Non-Reactive**	
	Western Blot:	☐ **Reactive**	☐ **Non-Reactive**	☐ **Indeterminate**
Hepatitis B:	**HBsAg:**	☐ **Found**	☐ **Not Found**	
Hepatitis C:	**HCV EIA:**	☐ **Repeatedly Reactive**	☐ **Non-Reactive**	

5. **Source Individual was NOT Tested:** *(Testing Agency: Please Check ALL Reasons Below that Apply)*

☐ **Source individual refused testing / to have blood drawn.**

☐ **Source individual did NOT present to this facility**

☐ **Other** (specify): _____

_____

6. Name of Local Health Department / Testing Agency	Agency Phone Number ( )		
Agency Address (Number & Street, etc.)	City	State	ZIP Code
7. Authorized Signature at Testing Agency Date	8. Agency Authorized Name (Printed or Typed)		
	9. Title of Authorized Signature		

NOTE:

- The name of the source individual tested and his/her test results are confidential according to Michigan Compiled Law, 333. 5111(2) and 333.5131.
- A person who discloses information in violation of this section is guilty of a misdemeanor.

***HIV Rapid Tests are for screening purposes only. A reactive Rapid Test requires follow-up testing to confirm patient status.**

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SECTION 4 – To be completed by the Local Health Department, or Agency Doing Testing:

- Return Section 4 to Employer of Exposed Individual.

1. Name of Employer of Exposed Individual		
2. Employer Address		
3. Name of Exposed Individual	4. Date of Exposure	
5. Source Individual was Tested for: ☐ **HIV** ☐ **Hepatitis B** ☐ **Hepatitis C**		

6. At the Request of the Exposed Individual, (See Page 1, Section 1) a Copy of the Test Results on the Source Individual were forwarded to the following:

☐ **The Exposed Individual** (named above)

☐ **Physician designated by the Exposed Individual** (specify)**:** _____

_____

☐ **Other Health Care Professional** (specify)**:** _____

_____

NOTE: Michigan law (M.C.L. 333.5133) prohibits the unauthorized disclosure of test results without the consent of the test subject. M.C.L. 333.5204 allows test results to go to the above as specified by the exposed individual.

7. **Source Individual was NOT Tested:** *(Testing Agency: Please Check ALL Reasons Below that Apply)*

☐ **Source individual refused testing / to have blood drawn.**

☐ **Source individual did NOT present to this facility**

☐ **Other** (specify): _____

_____

8. Name of Testing Agency	9. Agency Phone Number **( )**		
10. Agency Address (Number & Street, etc.)	City	State	City
11. Authorized Signature at Testing Agency Date	12. Agency Authorized Name (Printed or Typed)		
	13. Title of Authorized Signature		

NOTE TO EMPLOYER:
If the source individual has refused testing, you may wish to proceed with a petition to the circuit court. Contact the circuit court for a copy of the "Petition for Testing of Infectious Disease" form, and proceed as instructed. It is also recommended that you contact the local health department to alert them that you are filing a petition under 333.5205 of the Public Health Code.

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